UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ZIANA (clindamycin/tretinoin)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Extensions and options_____ Fax:_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Age requirement - 12-19 years old.
- Patient must try and fail on a combination of both generic tretinoin gel and clindamycin gel.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity.

4/30/7